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ABSTRACT

A theory of normal mother-infant relationship based on Margaret Mahler's theories is the basis of a treatment program for disturbed mother/infant relationships. This theory includes the concept of symbiosis which for the child is an undifferentiated condition, a fusion with the mother where the two have a common outward border, thereby protecting the immature ego of the child against too early stress. Signs of disturbed symbiosis in the child include tenseness, jerky movements, low muscular tone, avoidance of body contact, brief or avoided eye contact, quietness, late babbling, and excessive screaming. There is a lack of synchrony in interaction between mother and child. After the symbiosis stage comes the differentiation phase which is the beginning of independence. Signs of disturbed differentiation include anxiety and the lack of desire for new discoveries on the part of the child. This treatment model aims to help the the mother and child establish a symbiotic relationship and initiate the psychological separation process. Treatment supports these processes by removing obstacles and enhancing the natural mother-child contact channels. It is vital for successful treatment to identify bonding failures early before the end of the first year. Although the therapeutic unit is the mother/child dyad, groups of mothers and children meet regularly. Five levels of therapeutic intevention are used, including direct intervention with the mother and child, work with the mother, work with the baby, family therapy, and social work. Preliminary results indicate successful achievement of goals in the majority of cases. (ABL)

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THERAPEUTIC TREATMENT OF EARLY DISTURBANCES IN THE MOTHER-CHILD INTERACTION

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Paper presented at the Third World Congress of Infant Psychiatry in Stockholm, August 1986

THERAPEUTIC INTERVENTION DURING THE INFANT YEAR - A MODEL FOR TREATMENT OF EARLY DISTURBANCES IN THE MOTHER-CHILD RELATIONSHIP

'Victoria Garden' is a treatment unit for preschool children and their families connected to the Child Psychiatric Clinic in Malmö. The treatment takes place in an old house by the sea where children and their parents are transported in mini-buses. The activity started in 1965 as a specialized nursery school and has gradually developed. Today there are two morning groups for treatment of emotionally disturbed children and another two groups with intensive relationship therapy for parents and children - one group for the ages 1 1/2 - 7 years and another for infants 0 - 18 months. This article deals with the latter which consists of six mother-child couples that meet every weekday afternoon. The duration of the treatment varies from 2 to 8 months which implies a gradual change of the composition of the group. The treatment team consists of three specially trained preschool teachers and one psychologist.

In recent years there has been an increased interest in the treatment of early disturbances in adults, eg., the borderline problems and narcissistic disturbances generally considered to originate from the infant years (Blanck and Blanck, 1974) which are the ones decisive of our personality development (Parkes, 1982). This interest has encouraged descriptions of the aspect of these disturbances when established and further developed (Bowlby, 1967; Bowlby, 1969; Ainsworth, 1978). Today there are also an increased interest in developing treatment methods in order to prevent these early personality disturbances.

Research and development work on child birth and infancy is a long neglected area which during the past twenty-

five years has experienced an enormous up-swing, today being an inter-disciplinary science involving biology, ethology, neurology, pediatrics, developmental psychology and so-called infant psychiatry. This interest can be noted in an increasing number of dissertations and articles published ,symposia and conferences.

When it comes to the treatment of early disturbances the reports are fewer, however. Selma Fraiberg and her colleagues in the USA were some of the first ones to publish reports on working directly with the dyad, the mother-child relationship. Their reports are still the most interesting contribution in the field (Fraiberg, 1980).

At 'Victoria Garden' we approached these problems with a genuine desire for more prophylactic methods within child psychiatry, as the inquiries for treatment of still younger children increased at the end of the seventies. In response to this demand, we started a group for relationship therapy of small children (1 - 3 years) and their parents in 1978. These children had usually shown some kind of psychosomatic symptoms for which the Child Welfare Centre or a pediatric clinic had been consulted which in turn had referred the patients to us. Gradually we developed a therapeutic model to work with the parent-child relationship and made a great many new experiences from working with communication on a level where the body language is still predominant in the interaction. A great deal of the work meant helping

the parents to discover and interpret the child's signals and to give answers which could lead to an increased contact with the child. This was carefully documented as well as background information about our patients. In common the women had a negative experience of the pre-natal period and they maintained that difficulties with the child had started already during the first year. Striking, but perhaps not amazing, was the negative or ambivalent relationships the women often had with their own mothers. These observations are also supported by other researchers (eg., Lagerkrantz, 1979; Uddenberg, 1976).

These experiences, in addition to the fact that we had obtained good results with relatively short treatment periods, made us initiate, in 1982, a treatment group for mothers with infants, A great advantage to offer treatment during the child's first year is that it can be offered to all mothers and not as before to housewives exclusively. (In Sweden mothers have paid maternity leave for 9 months). As there was no mother-infant therapy of this kind to copy in Sweden, the planning activites had to begin from scratch.

In this article our treatment model and the theoretical basis for this model will be presented.

Some theorethical starting points

Through our work with 1 - 3 year-olds and their mothers we were convinced that the treatment had to be concen-

trated on the mother-child dyad, thus excluding models one-sidedly aiming at the mother or the child. We looked for a theoretical model focusing on the development of object relationship, ie., on how emotional relationships to other human beings are formed. Margaret Mahler's (1975) theories on relationship development is the theory most in accord with our own observations and that is the one we have chosen as a basis in our work.

Mahler divides the period 0 - 3 years into phases describing the development in the relationship to the first object. The first phase is the symbiosis, a time when the child is presumed to experience a fusion with the mother which goes on from birth until the end of the first year. The first month of "normal relative autism", described in this theory, has been abandoned, even by Malher herself, after findings in modern research of the interactive competence in infants even at birth (Call, 1983; Bower, 1977; Schaffer, 1977). The symbiosis reaches its peak at the age of 4 - 5 months when the so-called "hatching" takes place. Then the differentiation phase starts, where the central point in the relationship development is the fact that the child starts separate himself from the mother. This phase is the introduction to the individuation- and separation processes continuing parallelly up to the age of three when the child presumably has obtained emotional object constancy.

Symbiosis

A fundamental concept of Mahler's is the symbiosis which is considered the origin of human existence and the soil for all other relationships in the future. The symbiosis for the child is an undifferentiated condition, a fusion with the mother where the two have a common outward border. The purpose of the symbiosis is to protect the immature ego of the child against too early stress, in order to enable him to mature and begin differentiating, first inner from outer experiences and then self from object (Mahler, 1968; Mahler, 1975). The symbiosis is a closed circuit, founded on a mutual emotional attachment between mother and child. A sign that this attachment has been established is the selective smile by the age of 4 - 5 months. This signal to the mother to be selected by and special to the child deepens the bonds. Mother and child do not, however, participate in the symbiosis on equal terms. To the child the dependence is complete while to the mother it is relative. During this period the mother is the auxiliary ego of the child (Spitz, 1965) and the way in which she cares for the child and her susceptibility to the child's signals are essential factors (Winnicott, 1960) eventually facilitating the psychological birth of the child.

The child is already from the start active in creating special bonds to the mother by means of his innate signals (Hwang, 1984): eye contact, crying, smile, body language and screaming. Above all, the eye contact is *crucial in all contact building (Robson, 1967) and the*

child's ability in this respect exists from the very beginning and the ability to stay in contact increases week by week. The eye contact is needed to give the child a feeling of tranquility, a sense of security and stability. Besides, the eye contact is important feedback to the mother as it confirms whether her care has been correctly performed and at the right time (Duve, 1972). The signals are meant to elicit the mother's care, initially for survival. The child is also from the beginning geared to look for social stimuli like the voice and the face. Above all, the mother-child system is a system of communication. One objective of the symbiosis is to facilitate synchronization in the interaction, i.e., a mutually increasing ability in reading signals and body language (Stern, 1977).

Of importance during the initial phase of the symbiosis is that the child is helped to achieve relaxation and to maintain homeostasis. This process is dependent on the mother's care, but the child also has an innate ability to actively participate in the maintenance of the homeostasis (Escalona, 1968). This first care is mainly conveyed by the mother through body contact with the child, partly through stimulation of the skin and partly through deep sensibilization as lifting and carrying. This type of contact helps the child to relax and affects the breathing so that it becomes stabilized and deeper (Duve, 1974). The mother's voice also transmits tranquility to the child. A sign of symbiosis is that

the infant forms himself along his mother's body ("molding"). Through the body contact the child achieves his first experience of a relationship. The infant is dependent on this body perception to discover the surrounding world. Without it the child loses its concept of reality. Later on in the symbiosis distance perception is developed and the child is then able to experience contact without physical closeness which increases his sense of security. Another sign of symbiosis is that the child and the mother establish a common rhytm.

Signs of disturbed symbiosis in the child

Disturbed symbiosis in the child can, among other things, manifest itself in the following way. The child is tense, sensitive to stress, his movements are jerky and irregular or on the contrary languid and with low muscular tone. He avoids body contact and does not mold himself in his mother's arms. Eye contact is brief or avoided completely (Main and Weston, 1982). The smile fails to appear or passes quickly and never reaches the eyes. The child is quiet and babbles late and seldom. Excessive screaming and the difficulty in finding rest is conspicuous, as is the lack of rhytm. He behaves in an unsatisfied way and is hard to console. There is a lack of synchrony in the interaction with the mother (Greenspan, 1981).

Differentiation and practicing phase

The differentiation phase is the beginning of the development of independence. The child's attention is direc-

ted more and more outwards, outside the symbiotic sphere. Parallelly there is a perceptual and sensorial maturity. The child begins to examine the mother's body: pulls her hair, puts his fingers in her mouth, etc. Body contact is important in this process of establishing borders. At the same time the exploration continues on a visual level (checking back) and the child can be calmed and consoled only by looking at the mother (visual refuelling).

The next step is to examine other people's faces and compare them to familiar ones and this is when fear of strangers appear. Perhaps it is not really fear, as those children who have experienced a secure symbiosis rather show reservation and curiosity when meeting new people. Now the mother has to give up her symbiotic mothering and encourage the child's need of more distance. Her task is now rather to draw lines, protect and exist as a secure basis in the child's world, ie., to adapt herself to the child's increased independence. The subsequent practicing phase is characterized by the child's rapidly increasing motor development. He learns how to creep and walk and can leave his mother. His curiosity is great. In this phase the child's attention is on the surrounding world but the mother has to be present for his need of emotional refuelling.

Signs of disturbance in the differentiation and practicing phase

If the symbiosis has been delayed or otherwise disturbed, the differentiation will come either too late or too early. Too late if the mother has been emotionally cut-off or depressed. If, however, the symbiosis has been erratic and/or too tight and if the mother has been ambivalent towards the child and to her own role as a mother, the child struggles to differentiate himself early. In this case, the child has not had time enough to collect sufficient basic trust and reacts easily with stranger anxiety. These children are also later overwhelmed by anxiety as the ego is precocious and thus vulnerable (Mahler, 1975). They have a forever searching anxiety, are always on the go and do not look for their mothers for emotional refuelling. Other signs of disturbances during this period are not to react at all on an occasional separation from the mother or in front of strangers, or to react with panic when separating and to be very hard to console. Children who continuously cling to their mothers at the end of the first year, who do not examine their surroundings and lack the desire for new discoveries, signal conflict.

Introduction to the 'Victoria Garden' Model

In the 'Victoria Garden' treatment model we are mainly using two processes: the one aiming at helping mother and child in establishing a symbiotic relationship and the other at assisting mother and child in initiating

the psychological separation process.

The basis for the concrete treatment is then to support these processes by removing obstacles and enhancing the natural contact channels that exist between mother and child.

We are not aiming at achieving comprehensive changes in families or at producing deep personality changes or curing lingering mental suffering. A great many social problems have to be followed-up by others. Our ambition is principally to bring about changes in the mother's ability for mothering and to support attachment processes. Furthermore, to help the children to break negative response patterns and to encourage their inclination to contact.

The symbiosis concept is crucial in our work. To enter a symbiotic relationship implies such closeness to another person that it can evoke fear and result in conflict, especially if the mother's own experience of early care and close contact have been negative. Ways of reacting to this conflict can be to become depressed, overwhelmed with anxiety or to get other psychic symptoms (Brockington, 1982). The mother then often becomes emotionally inaccessible to her child, avoids body contact and reacts with irritation to the child's needs. The child who initially is seeking contact and closeness is then left out and reacts with symptoms (Haine, 1982). When the mother is uncapable of establishing a bond with her child, it is difficult for her to interpret the

signals and there is a vicious circle of misunderstanding and lack of contact.

"I can't feel anything for him"

"The damned kid wants to force me to change my life"

"I have terrible thoughts of how I might hurt him"

"I am good for nothing as a mother"

The desire to get on well with the child is as obvious as the ambivalence to and fear of closeness to the child. The child constitutes a strong motive for change. To his parents an infant represents hope and a longing for renewal in themselves (Fraiberg, 1980). The susceptibility to change and the relative openness of the defence structures during the puerperium, combined with the mother's fundamental wishes for her child's well-being, facilitates the motivation for treatment during this period of her life.

It is vital to identify bonding failures early, as the possibility to repair is easier when the child is under 1 year and still in the phase when symbiosis normally takes place. Most of the children referred to us have been below the age of 4 months. It is harder to re-establish a symbiotic relationship when the child is proceeding in his development of independence and has achieved ability to move freely and is on his way to separate from the mother.

Prophylaxis

In order to work prophylactically and offer treatment quickly, we have made the procedure of referral as informal as possible. Frequently we have unplanned visits for motivation purposes. We also visit other clinics to help motivate mothers for treatment. We give priority to the mothers with the youngest children. A two-week-old baby from the Pediatric Clinic with whom the mother cannot have body contact takes precedence of a seven-month-old baby with feeding problems. At times we overbook if the group is stable. At other times we might work polyclinically with a mother-child couple until a place can be offered in the group. We receive patients through the Maturnity Welfare Centre, the Maturnity Clinic, the Child Welfare Centre, the Pediatric Clinic, the Child Habilitation Centre, the Social Welfare Office and the Psychiatric Clinic. A great many of these clinics have not had any cooperation with the Child Psychiatric Clinic before. Since 1982, when we started to treat infants, we have worked to build a network with others working with infants. Through lectures, seminars, consultations and documentations we have tried to spread knowledge of signs of early disturbances in the mother-child relationship to clinics and agencies who come in contact with infants and mothers.

Contact during pregnancy

During the last few years pregnant women have been referred to us because of emotional conflict around

pregnancy, such as strong ambivalence towards the child, excessive fear of labour, fear of becoming a mother, depression and denial of pregnancy. These women come once a week to individual sessions where they get a chance to explore their feelings in connection with the expected child and the new role of becoming a mother. We also work on facilitating the process of intra-uterine bonding. One way to achieve this is to increase awareness of fetal movements and rhytm and to find all signs of its presence. To encourage expression of fantasies and ideas about the child helps the mother to take ownership of the baby and to make him more real. Having a relationship with the baby during pregnancy facilitates bonding once the child is born. Therefore, we believe that it is valuable to work with disturbances in bonding already during pregnancy and this is a part of our programme that we wish to develop.

The Therapeutic Context

As mentioned above, the therapeutic unit is the mother-child dyad. The therapeutic context, on the other hand, is the group of mothers meeting regularly. The social context of this group has multiple functions in the treatment model and actively supports the individual processes. First, the group functions as a confirmation of the identity of the mother-child unit. Each mother-child unit has entered into this group for different reasons, and each has a process of its own. Yet, in the context of the group, this change process is monitored,

evaluated and constantly confirmed. This is done informally, in group therapy, and through various forms of ceremonies and celebrations. As the treatment periods vary from unit to unit, the group is constantly renewed, thus facilitating the socialization of new mothers entering the group.

Several women have little experience of children and the group offers the opportunity to observe, compare and learn about them. Furthermore, the mothers are given the possibility to "train" in contact with another child the things that seem too provoking in contact with their own. Sometimes we work in small groups with those who have similar problems or children of the same age.

A reoccurring observation is that many of our women have a weak female identity and are inexperienced in the "world of women", not to mention the "world of mothers". Frequently they live isolated lives, lack female friends and do not have traditionally feminine interests. For many of them our group is the first experience of intimate and confidential relations with other women.

Once a week we have group therapy. The separation with the children before these sessions as well as the reactions at the subsequent reunion give rise to quite a few interventions and discussions. The contents of the group sittings are directed by the mothers' needs and subject matters as pregnancies, deliveries, loneliness, marriage and difficulties in being single parents are brought up. The mothers are welcome to participate in the group

sittings also after concluded treatment at 'Victoria Garden' which serves as a form of follow-up.

Levels of therapeutic intervention

Since bonding problems are complex phenomena involving marital, interpersonal and intrapersonal levels, we use an eclectic model which has proven to be flexible and of considerable value.

We distinguish between five levels of therapeutic intervention: direct intervention in the mother-child relationship, individual work with the mother, direct work with the baby, family therapy and finally social work and network.

Direct Intervention in the Mother Child Interaction

This is no doubt the most important method of intervention. The direct therapeutic work focused on the relationship is the cornerstone in our model, the main objective being to deal with conflict, to monitor interaction patterns, and to increase interaction intensity, qualitatively as well as quantitatively. In the daily work we observe a lot of conflict, ambivalence, and misunderstanding between mother and child. Our setting gives us a chance to observe the interaction as it enfolds, preventing us from relying strictly on verbal reports and mothers' interpretations. This also gives us the opportunity to intervene in critical incidents, to stop the process right then and deal with what happens

in the "here and now".

Pia (4 months) has problems gaining weight but is full of vitality and eager for contact. Her mother enters the room and Pia registers her voice and starts looking for her. She gets her into the field of vision. Her mother notices and turns around bothered. Pia continues looking, has renewed eye contact with her mother who laughs embarrassed, breaks the contact and turns her back to the child. Pia continues seeking contact. Later the mother turns her head and is again caught by Pia's eye. The mother says: "Well, won't you give up" and puts herself behind the child where it cannot see her.

T: You child is looking for you.
M: Well!
T: She seems interested in looking at you.
M: Why should she look at me.
T: To her you are the most important thing in the world.
M: (Seems surprised)
T: You feel embarrassed when she looks at you
M: Well, it is as if she wanted something and I don't know what.
T: Perhaps you are what she wants.

The mother then sadly starts telling how she had discovered the pregnancy too late to have an abortion, that she had thought of giving the child up for adoption and that up to now she had not really decided what to do.

Liselott is feeding her child (6 months) quickly and mechanically without realizing that the child cannot eat so fast. He often turns away his face, waves his arms and chokes. The mother feeds the child the whole jar even if his signals of being filled- up and feeling bad are quite obvious. The meal ends quickly and afterwards the child withdraws and does not want contact. The mother who wants to play feels rejected and turns to somebody else for contact.

Of further importance is to make the child real and personal to the mother by constructing a mental picture of him in the mother's mind and by reconstructing his history. This process includes among other things the

bringing of attention to important steps in the child's development and the commemorating of these steps with the help of ceremonies and celebrations. Another aspect of this is, in fact, the documentation of the child's development, for example, with the help of pictures, albums, and diaries. We also work with the dyad, establishing and enhancing bonds by means of sensual activities, helping the mothers to open up and to experience enjoyment with the child. The channels we use are body contact, eye contact and verbal contact, as these are often being blocked. Below follow some examples of disturbances in the various contact channels.

Body contact

Birgitta is constantly avoiding body contact. When feeding her child she holds it at a distance. She never caresses him and at times when body contact is a must, as during diaper changes, it nauseates her slightly. Her hands are cold and as a protection against the physical contact she has extremely long red nails which prevent her from handling the child in a natural way. The child is very jerky, lacks rhytm and has a strange movement pattern and a speeded tempo.

When Sara bottle-feeds her child (2 months) she props him up against pillows or puts him in a baby-sitter with the excuse "That's the way he wants it" which the child rightfully confirms by defending himself and becoming rigid when she takes him in her arms.

Eye contact

Linda never manages to look at her child straight in the face and during diaper changes only concentrates on the lower part of his body, looking for rash etc. During feeding she puts the child on her lap with his back towards her and then tries to place the spoon in the child's mouth. The child is gazing emptily into space avoiding eye contact with everybody.

Verbal contact

Anita rarely talks to Jens (6 months) and they have a very quiet relationship. Jens does not babble. When we encourage the mother to chat a little with Jens she she does not adapt her voice or tunes in to her baby but talks as if he were an adult. Jens starts crying. Anita says: "Look, he does not like when you talk to him".

In order to increase body contact we spend most of the time on the floor where there are ample possibilities to have skin as well as body contact, to "sniff" the child, to "bike", to lift, to blow on the stomache, examine the toes, etc. Here the inventiveness can be enormous. Our task is to lead the way and to create an open and positive atmosphere. We swim in a heated pool every other week, which also encourages body contact and relaxation. Sometimes we teach baby massage, specially to mothers with tense children. To many that is a secure way of approaching the skin contact as there is the "task of massaging" to hide behind.

Most of these mothers have had problems as far as eye contact is concerned. This is such a powerful channel and when mother and child look at each other, feelings are coming up to the surface. If these feelings are loaded with conflict there is a need to protect oneself by interrupting the eye contact. We use playful ways to bring about eye contact through games or by discovering development in the child.

To increase the verbal contact we act as models ourselves and chat with the children, receive their answers

with exaggeration, show delight and answer back in order to stimulate them to continue the dialogue. We sing together with the mothers and make up our own nursery rhymes suited to their children.

Direct Work with the Child

Our general attitude is to work on the dyad and not unnecessarily separate the mother and the child. Sometimes, however, it is of importance to work individually with some children to modulate the response of the child, i,e,, when the child's behaviour is too difficult for the mother to respond to or to cope with, for example, extremely active children who have a hard time to relax enough to be able to stay in contact. We also work with overly passive and depressed children to help them to be more inclined to respond and to be interested in contact. This is an important element in establishing channels of communication between mother and child, especially when the mother feels that her child is not available for contact with her.

Couple and family therapy

In cases of marital conflict we offer couple therapy. Few men have the possibility to participate in the daily activities but will come to family sessions once a week. Our working with "open doors" encourages quite a few fathers to come when they are off work for a day and they often take part when we go swimming with the children. However, since we started to work with infants

no father has sought help for himself or told us that he has experienced an emotional conflict in the relationship with his child. Some fathers have not been particularly interested in the child and others have had little time for the child without expressing neither as a conflict. In certain families where the mother has been emotionally unavailable because of psychic problems, the father has established the symbiosis with the child.

Approximately half of our mothers are single and relationships or contacts with the father have been nonexistant. We have supported and brought about speedy paternity investigations. These can delay the relationship development as so much energy and emotional involvment are invested in them.

Most of the women have a complicated relationship to their own mother which is sometimes manifested by dissociation or aggressiveness, eg., "She has never cared about me and she doesn't even give a darn now that I've got a kid. I'll never be like her." In other cases we observe extremely close and unseparated relationships between mother and daughter, eg., "Mother comes every day to cook for me. I can only leave Lisa with her, not with my husband". As these grandmothers play an important role in the families, we invite them for visits and sometimes to family sessions.

Individual Therapy with the Mother

When it comes to the individual therapy with the mother, it is very difficult to give any over-all descriptions, as the therapeutic method we use is adapted to the needs of the mother which means that we are working with methods spanning from crisis intervention, supportive therapy, behaviour therapy and focused insight therapy. This eclectic mode of working has proved to be valuable so far. It is important to note, however, that the individual therapy we use focuses on the relation to the child in stressing issues of motherhood and obstacles in attachment.

Below is an attempt at classifying the mothers according to their type of problems connected with mothering and the therapuetic method chosen.

A first category involves women who have experienced some kind of trauma during the puerperium, a trauma that constitutes an obstacle in the contact with the child. In these cases we offer crisis therapy. Furthermore, together with these women we get in touch with the Maternity Clinic or the Pediatric Clinic to go through peri-natal traumas and complications together with the hospital staff.

> On her way out after visiting and talking with the mid-wife at the Maturnity Ward, 4 months after an extremely painful and complicated delivery, Carina exclaims beaming with joy: "Now I really feel like having given birth. Let's celebrate".

Another group involves young, often single, mothers living on the periphery of society. They often come from

homes with a history of separations and social difficulties. Interrupted schooling, no job stability, poor self-confidence and no stability in life. When these women have children they are unprepared with subsequent difficulties in their mother role.

> Linda, single, fired from her job because of poor attendance, lives with room-mate, discovers pregnancy in the 6th month, too late for an abortion, father of the child occasional acquaintance, does not visit the Child Welfare Centre, no preparations for the delivery or arrival of the child, no participation in the delivery. Afraid when the child screams, shuts off emotionally. Afraid not to manage with the child. Shows very little care.

These women are referred to us by the Social Welfare Agency who have doubts about their ability to manage a child. We give these women supportive therapy and intervene on psycho-social levels.

In still another group of women, the difficulties in the relationship with the child depend mainly on deeper unsolved intra-psychic conflicts. Early experiences of their own are aroused in conncection with child birth, remain unconscious and are sometimes projected on to the child.

> "He wants to decide over me. A struggle for power started as soon as he was born".
>
> "She understands me and consoles me in my anxiety".

These women have been considerably older than the above group, established in society, with educations and jobs, and often married or living together with the father of the child. Some of them are referred to us by the psychiatric clinic where they have sought help because of

phobias and anxiety. This group is offered focused short-term psycho-therapy.

A subgroup are those referred to us because of depression. The basic problems here often originate far back. These women have poor self-confidence and as mothers they experience quite ordinary difficulties with the children as failures and confirmation of their incompetence.

> "Poor child with such a mother".
>
> "I am so afraid not to make it as a mother".
>
> "He would be better off in an orphanage and if I committed suicide".

These mothers are offered supportive therapy where we concentrate on self-confidence, the mother's self-concept as well as her ability to take control of her life again.

Finally, one group consists of intellectually handicapped women where there have been doubts, on part of the Social Welfare Agency, whether they would manage to take care of a child. In these cases we have supportive therapy and behaviour therapy. Teaching and modelling is central here, along with contacts with other authorities, to build up a future protective network for the family. In these cases we have also made more formal assessments.

Some preliminary results

Since we started in 1982 we have treated 37 mother-child

couples at 'Victora Garden'. Still we cannot tell yet in a long-term perspective how the separation-individuation processes have proceeded. To have answers to these questions we have started a preliminary follow-up as when the first children have reached the age of 3. This age is chosen for theoretical reasons, as the child by then shonuld have obtained a certain degree of object constancy. Due to lack of resources we have not been able to do a formal evaluation of the programme. We have had spontaneous contact in most cases, however, up to a year after termination. What we can comment on with certainty, however, are the results obtained on concluded treatment and three months afterwards,

What then determines when to stop treatment and what is considered a good treatment result? First of all a treatment contract is drawn up with all parents prior to treatment.

> "I wish she would let me feed her".
>
> "I'd like to get her calmer (9 months) and happier without having to nurse her and carry her around all the time".
>
> "I'd like for him to stop that awful screaming of his and be a little cuddly so I could feel he really was my kid".

The wording of the contract is important as it gives the mother a concrete goal to try to obtain, a goal which in simple words expresses the contact level she wants to achieve. When the contract has been fulfilled, we complement with our assessment as to the functioning of the relationship.

In the last mentioned case example the mother and the child built up a close relationship which was stable to the extent that in our opinion it would manage possible stress in the next phase. The child relaxed and was bodily close. The eye contact was intense and he clearly showed that he preferred his mother. Secure attachment had been established. Below are some examples of the criteria we use to assess attachment.

> In the mother: to have developed caring behaviour towards the child, to have "opened up" emotionally to the child, to be able to feel joy in the contact, to be able to see the child's signals and respond to them, to be able to protect the child and give priority to his needs.
>
> In the child: to have achieved relaxation and rhythm, to differentiate the mother from others and to show preference for her, to show separation and stranger reaction in the differentiation and practicing phase, to be interested in contact, to smile and be able to maintain eye contact, to show interest in the surroundings during the second half-year and to have joy of discovery.

With these criteria the treatment has been successful in 26 cases. When analysing the 11 cases where mother and child did not succeed in building-up and involving themselves in a satisfactory symbiotic relationship, we find common factors. The women who have not been able to attach to their child, have been unable to form a deeper alliance with us as well. They seem to lack the ability to establish deeper bonds and have never had stable and long-lasting relationships. These women have early disturbances of their own and have narcissistic character traits. They cannot "receive" another human being and the relationship with the child is directed by

their own needs. Here we observe a struggle between mother and child for gratification of needs.

> T: "Sara, your child is crying desperately. Is it feeding time?"
> S: (spitefully) To hell, I've got to have a cig first."

We are still of the opinion that the treatment has been of value to these mothers and their children. They have learned about the needs of infants, have come to know their child and his characteristics and developed mothering skills. In some cases they have come to understand their own limitations and learned how to build in structures to protect the child. But in situations of stress, conflict and other strain they have not been able to give priority to the child's needs but abandoned him emotionally.

Five of the children in the above-mentioned cases had their conditions of custody changed. Two were placed with the biological father and three were placed in foster care.

The children who in these cases had an erratic and unpredictable symbiosis became passive, little demanding and uninterested in contact. In serious cases they slept extremely much, became emotionally self-sufficient and regressed in their motor development. Other researchers have had the same experience (Brazelton, 1983).

The majority of the children that were followed up at 3 years of age gave promising indications as far as the stability of the positive changes that had occurred in

the relationship with the mother. We observed well functioning dyads which were characterized by independence, warmth and joy. The children were well developed and easy to contact.

We have documented all treatment processes (some with video) but have not yet had the resources to analyse this material but hope to be able to present it together with the follow-up later on.

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